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# October 2019 Integrated Outpatient Code Editor (I/OCE) Specifications Version 20.3

MLN Matters Number: MM11412
Related Change Request (CR) Number: 11412
Related CR Release Date: August 30, 2019
Effective Date: October 1, 2019
Related CR Transmittal Number: R4383CP
Implementation Date: October 7, 2019

## PROVIDER TYPES AFFECTED

This MLN Matters Article is for institutional providers and suppliers billing Medicare Administrative Contractors (MACs), including the Home Health and Hospice MACs, for services provided to Medicare beneficiaries.

## PROVIDER ACTION NEEDED

CR 11412 provides the Integrated Outpatient Code Editor (I/OCE) instructions and specifications for the Medicare Integrated OCE version 20.3 used as follows:

- Under the Outpatient Prospective Payment System (OPPS)
- For Non-OPPS hospital outpatient departments, community mental health centers and all non-OPPS providers
- For limited services when provided in a Home Health Agency (HHA) not under the Home Health Prospective Payment System
- For a hospice patient for the treatment of a non-terminal illness

Make sure your billing staffs are aware of these changes.

## BACKGROUND

CR11412 informs the MACs and the Fiscal Intermediary Shared System (FISS) maintainer that the Centers for Medicare & Medicaid Services (CMS) is updating the I/OCE for October 1, 2019. The I/OCE routes all institutional outpatient claims (which includes non-OPPS hospital claims) through a single integrated OCE.



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The following table summarizes the modifications of the I/OCE for the October 2019 V20.3 release. Readers should review the entire CR 11412 document and note the highlighted sections, which also indicate changes from the prior release of the software. CMS has added some I/OCE modifications in the update retroactively to prior releases. If so, the retroactive date appears in the 'Effective Date' column of the below table. CMS will post the I/OCE specifications at http://www.cms.gov/OutpatientCodeEdit/.

| Effective Date | Edits Affected | Modification |
|---|---|---|
| 10/1/2019 | | Update the Claim Return Buffer Table to add new field “Return Code” |
| 10/1/2019 | 1, 3, 5 | Update diagnosis code editing for validity, gender, and external cause of morbidity, based on the FY 2020 ICD-10-CM code revisions to the Medicare Code Editor (MCE). |
| 10/1/2019 | 2 | Update the age range for Maternity diagnoses to a low age of 9 and a high age of 64. If outside this range an age conflict exists and edit 2 is returned. This change is based on the FY 2020 ICD-10-CM code revisions to the MCE. |
| 10/1/2019 | 109 | Update the Code first list for mental health diagnosis reporting, based on the FY 2020 ICD-10-CM code revisions. |
| 1/01/2019 | 92 | Implement logic to bypass edit 92 when a device procedure is reported with modifier CG. The edit is bypassed only if the device procedure reported with modifier CG is on the “Edit 92 Modifier Bypass” list. See **Device Dependent Procedure Editing and Processing** in the I/OCE specification document attached to CR 11412 for more information. |
| 7/01/2019 | | Update logic to Return Payer Value Code QW and the applicable Value Code amount on an adjusted Partial Hospitalization Program (PHP) interim claim, if Condition Code MW is supplied on input. See **Partial Hospitalization and CMHC Processing logic in** the I/OCE specifications for more information. |

| Effective Date | Edits Affected | Modification |
|---|---|---|
| 7/01/2019 | 110 | Apply mid-quarter edit 110 (Service provided prior to initial marketing date) to HCPCS Q5107, if reported before 07/18/2019. |
| 7/01/2019 | 22 | Remove modifier CB from the list of Valid Modifiers retroactive to July 1, 2019 |
| 4/01/2019 | 13 | Add edit 13 to the list of edits that can be bypassed when using the Contractor Bypass logic. |
| 1/01/2016 | 93 | Update edit 93 to return a line item denial or rejection flag of 1, retroactive to its effective date (1/1/2016). |
| 10/1/2019 | | Revised documentation on the processing action of HCPCS 94762 when it is reported without critical care. See **Critical Care Processing** for documentation update. |
| 10/1/2019 | | Make all HCPCS/Ambulatory Payment Classification (APC)/Status Indicator (SI) changes as specified by CMS (quarterly data files)<br>• Comprehensive APC Exclusion list<br>• Device Procedure lists **(edit 92**)<br>• Terminated Device Procedure for offset APC<br>• Edit 99 Exclusions list<br>• FQHC Non-Covered list<br>• Non-Covered Service list **(edit 9)**<br>• Service not billable to the MAC **(edit 72)**<br>• Edit 92 Modifier bypass list<br>• Low cost skin substitute list (edit 87) |
| 10/1/2019 | 20, 40 | Implement version 25.3 of the NCCI (as modified for applicable outpatient institutional providers). |

## ADDITIONAL INFORMATION

The official instruction, CR 11412, issued to your MAC regarding this change, is available at https://www.cms.gov/Regulations-and-

Guidance/Guidance/Transmittals/2019Downloads/R4383CP.pdf.

If you have questions, your MACs may have more information. Find their website at http://go.cms.gov/MAC-website-list.

## DOCUMENT HISTORY

| Date of Change | Description |
|---|---|
| September 3, 2019 | Initial article released. |